# INDIVIDUALIZED SERVICE PLAN

**If applicable: Medicaid # _____**

**DMAS Provider ID#_____**

**Resident's Name:_____ Name of ALF: _____**

**See reverse side for signatures and additional information.**

***Description of needs is based upon the UAI, medical reports, and any additional assessments necessary to meet the care needs of the resident.***

**A. If the resident lives in a building housing 19 or fewer residents, does the resident need to have a staff member awake and on duty at night? Yes No**

| **B.** Description of Needs and Date Identified | Services to be Provided | Persons Who will Provide Services | When and Where Services will be Provided | Expected Outcomes/Goals (Include Time Frames) |
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**Resident's Name: _____**

| **B.** Description of Needs and Date Identified | Services to be Provided | Persons Who will Provide Services | When and Where Services will be Provided | Expected Outcomes/Goals (Include Time Frames) |
|---|---|---|---|---|
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**SIGNATURES:**

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Staff Person Who Completed Plan** | **Date Plan Completed** | **Resident** | **Date** |

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Licensed Health Care Professional (630.J) (For Assisted Living Care Residents)** | **Date** | **Other, if any, Involved in Development of Plan (Specify Title/Relationship)** | **Date** |

**PLAN REVIEW/MODIFICATIONS**

**NOTE: Changes in plan should be initialed by staff person making change, resident, and for assisted living care residents, licensed health care professional (630.J).**

**Staff Person Designated to Review, Monitor, Ensure Implementation, and Make Appropriate Modifications to Plan: _____**

**Dates Implementation Monitored and Initials: _____ _____ _____ _____ _____**

**SIGNATURES:**

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Staff Person Who Completed Plan Review** | **Date** | **Staff Person Who Completed Plan Review** | **Date** |